Montana Medicaid and Mental Health Services Plan
Partial Hospitalization Services
CERTIFICATE OF NEED

Recipient Name: _____ Date of Birth: _____

Address: _____

SSN: _____ Medicaid/MHSP ID Number: _____

Admitting Facility: _____ Provider Number: _____

Proposed Admission Date: _____ Expected Discharge Date: _____

The interdisciplinary team certifies the following:

1. The recipient is experiencing psychiatric symptoms of sufficient severity to create moderate to severe impairments in educational, social, vocational, and/or interpersonal functioning; (include documentation)
   _____
   _____
2. The recipient cannot be safely and appropriately treated or contained in a less restrictive level of care; (include documentation)
   _____
   _____
3. Proper treatment of the beneficiary's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a physician; (include documentation)
   _____
   _____
4. The recipient can be safely and effectively managed in a partial hospitalization setting without significant risk of harm to self or others; (include documentation)
   _____
   _____
5. The services can reasonably be expected to improve the recipient's condition or prevent further regression; (include documentation)
   _____
   _____
6. The recipient has exhausted or cannot be safely and effectively treated by less restrictive alternative services, including day treatment services or a combination of day treatment and other services. (include documentation)
   _____
   _____

_____ _____
Print/Type Name of Physician Team Member Title

_____ _____
Signature of Physician Team Member Date

_____ _____
Print/Type Name of Mental Health Professional Title

_____ _____
Signature of Mental Health Professional Date

_____ _____
Print/Type Name of Case Manager Mental Health Center

_____ _____
Signature of Case Manager Date Telephone Number